

no longer have an incentive to keep costs down.

2. HMSA has become, for all practical purposes, the only buyer of physicians' services in Hawaii because Kaiser employs its physicians on a full-time basis. If a non-Kaiser physician cannot work for HMSA, she or he cannot make a living in Hawaii. HMSA is therefore free to, and in fact does, dictate terms to its participating providers. Hawaii's physicians, in return, are coerced into accepting HMSA's terms even though, in large measure, HMSA seeks to substitute, in cases that matter, its own treatment decisions for the participating physician's, and even though reimbursements for important services are all too often wholly inadequate. For the most part, HMSA's participating physicians don't speak out because they are intimidated to remain silent.

3. Health plans employ various means to ration health care by creating disincentives for physicians to treat patients. Inadequate reimbursements, for example, for certain vaccines or for lengthy and complex office visits is one form of disincentive. A more insidious form of disincentive is a gainsharing program. Under gainsharing, health plans maintain treatment profiles of physicians and reward physicians with cash for treating patients less and for limiting advocacy on behalf of the physician's own patients. HMSA claims its gainsharing programs merely reward good physician practices.

4. The Board of Directors of HMSA, a tax-exempt mutual benefit society, has already demonstrated its disdain for its membership. Last year, on short notice, and with full knowledge that many Hawaii physicians were attending a conference on Kaua'i, the Board called a special meeting to be held the day before Election Day. The Board loaded the meeting with HMSA employees and HMSA members who worked for firms friendly to HMSA. At the meeting, those present voted to change the number of member signatures necessary to call a special meeting from 100 to 3% of the membership, about 18,000 signatures! They also significantly reduced the power of members to name directors.

Hawaii's consumers are thus faced with:

1. An all-powerful, tax-exempt, so-called mutual benefit society
2. that virtually monopolizes the Preferred Provider Organizations (PPOs) and is almost the only buyer of physicians' PPO services in this State;
3. whose board is insulated from member action because of changes made to its bylaws;
4. that cannot, by virtue of ERISA, be sued by its members in ways that the normal insurer can be sued by its policyholders or third parties, i.e. for bad faith refusal to settle or pay, or for general or punitive damages;
5. that by statute sets the criteria for other health plans under Hawaii's Prepaid Health Insurance Act
6. that is subject to only the most minimal of scrutiny and supervi-

sion by the Department of Labor; and

7. That has intimidated its participating physicians into abject silence and acceptance of inadequate compensation, with no right to appeal maximum allowable charges, and a contract that places ultimate power to determine what is appropriate treatment in the hands of HMSA directors whose primary duties are to the health plan and not to the patients.

If this situation does not require active state supervision and regulation, I don't know what does.

Universal Single Payer Health Plan — Answer to our Dilemma?

Ah Quon McElrath
Member, University of Hawaii Board of Regents

The irony of being the richest industrial nation is that the United States is without a coherent, comprehensive, universal health care plan for its 275 million residents. The result is 44.3 million residents without health care and over six million underinsured despite a still strong economy and low unemployment, inflation, and interest rates.

The increasing numbers of individuals without health care occur with the downsizing and merging of companies which result in huge layoffs of workers and the changing nature of work which has increased the numbers of part-time, contractual, and consulting workers who generally do not receive the benefits that regular full-time workers receive. Furthermore, there has been a decrease of unionized workers whose collective bargaining agreements usually provide health care.

For laid-off workers and those with pre-existing conditions, the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) and the 1996 Health Insurance Portability and Accountability Act (Kennedy/Kassebaum), respectively, have not been effectively helpful in the continuation of health care because premiums have been prohibitively high and include provisions that present difficulties with compliance and administration. For recipients of public payments and new immigrants, the effect of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (welfare reform) on continued Medicaid eligibility is murky.

Congress has skirted around the issue of providing health care for all Americans. What has been provided has been incremental and accretional and targeted towards specific population groups—the aged, disabled, and poor; ethnic groups such as the American Indians and Hawaiians; the military and veterans; individuals with named health conditions; and often only as a response to strong pressure from affected groups.

When the Social Security Act was promulgated in 1935, health care was not seriously considered since the effects of the depression were perceived primarily as an economic problem with its 16 million unemployed, closure of factories, breadlines, and massive dislocation of families who could not meet rental or mortgage payments. Policy makers did not think that congressional support for health care could be galvanized.

Following World War II, an attempt was made by the Truman administration to pass a national health insurance program. However, the organized resistance of the medical profession and hospitals with cries of "socialized medicine" doomed the attempt.

Discussion about health care lay dormant until the "great society" period of President Johnson. In 1965 amendments to the Social Security Act resulted in Medicare (Title XVIII) and Medicaid (title XIX). Medicare provides health care for the aged and the disabled and is funded through an employee/employer payroll tax (Part A-hospitalization) and a monthly premium and general revenues (Part B-medical services). Benefits do not include out-patient prescription drugs (with a few exceptions) or long-term institutional care (except after a 3-day hospital episode), both of which account for huge expenditures by the elderly themselves. Medicaid, for public assistance recipients and other income eligible individuals, is funded by states and the federal government under a federal matching device known as the Federal Medical Assistance Percentage (FMAP). FMAP is determined annually on a comparison between a state's average per capita income and the national average with a federal match not lower than 50 per cent nor higher than 83 per cent for every dollar spent for benefits. (Hawaii now receives 52 per cent in FMAP, although it was 50 per cent for many years.) Medicaid is a complex and complicated program with its system of basic and optional benefits and varying eligibility requirements.

In 1972 Congress combined the public assistance titles of the Social Security Act-Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Permanently and Totally Disabled (APTD) — into the supplemental Security Income Act (SSI), with complete federal funding. One of the options under this program was automatic eligibility for Medicaid, for which most of the states opted. Hawaii was not one of those states, citing its generous public assistance and Medicaid program as the reason for not so choosing.

In the early 1970s a bill to promote the formation of health maintenance organizations (HMOs) was enacted under the Nixon administration and largely prompted by Minnesota adherents of the idea, which already had its reality in the Kaiser plan, HIP of New York City, and the Group Health Plan of Puget Sound. The concept was not embraced wholeheartedly until the 80s, when insurance companies, under the rubric of "managed care," saw HMOs as a way by which money could be made. Thereafter, these companies purchased clinics, hospitals, laboratory facilities, and even mortuaries and cemetery plots. They promoted their for-profit HMOs as a good investment for investors and their highly paid CEOs.

"Managed care" took the medical profession and patients out of making health care decisions, especially those which affected the profit margin of HMOs.

Interestingly, market economics or making a profit, has affected the behavior of the traditional "blues" as well as the not-for-profit HMOs in the way they run their operations.

For a short period, "managed care" for government programs like Medicare & Medicaid and Private industry plans kept health care costs fairly stable, but there are signs that costs are beginning to rise. In 1999, over 4,000,000 Medical beneficiaries lost "managed care" coverage when insurance companies began "losing" money. Employer groups, now faced with the rising costs of providing care for their employees, have begun the cycle of increasing employee premium contributions, instituting caps, cutting benefits, and eliminating dependent coverage.

In 1975 legislation for national health planning and resources included the issuance of certificates of need for the acquisition of technology, changes in services, and the building and renovation of facilities such as hospitals and nursing homes. Certificates of Need were thought to be the answer to rising costs, promoting quality, and improving access to care.

In 1994 the Clinton administration attempted to increase coverage and community participation in health care. The attempt failed, despite leaving insurance companies as the principal player in health care, in the morass of an over 1,000 page bill which few took the time to read, let alone understand.

Thus, the health care landscape is littered with many make-shift attempts to contain costs, increase accessibility, and insure quality. There are the likes of Certificates of Need, Diagnosis Related Groups (DRGs), participating physicians (PARs), Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLMBs), Children's Health Insurance Program (CHIP), and other acronyms long forgotten.

There are hundreds of health care plans for public and private workers and their families sold by large and small insurance companies. Health care exists in Workers' Compensation, automobile insurance, homeowners comprehensive insurance, and individually purchased plans. Cost of these plans are usually borne by premiums paid by employers, employees, government entities, or by the individuals.

Coverage is spotty. Some plans provide coverage for the entire family, others only the employed member, others cover dependent at an employee's sole cost, such as Hawaii's 1974 Prepaid Health Care Act. Hawaii, the only state to have such a plan, is exempted from the preemption clause of the Employee Retirement Security Income Act (Erisa) by a congressional act after a successful court challenge by a local oil company. Benefits range from the adequate to the inadequate, with or without caps, deductibles, or co-payments. Most of the plans provide curative care, but few provide preventive care.

It is unlikely that Congress will soon enact a universal health plan to cover all residents of the United States, even though it would be a relatively easy conversion of either Medicare or Medicaid with the federal government's being the single payer.

Under this circumstance, individual states can become truly innovative about how they provide health care for all of their residents.

States can use the age-old concept of states' right, or devolution, as it is euphemistically called, to create their own universal single payer program.

There would be no difficulty in devising a universal single payer plan. There are many models already in existence, including that of the Canadian government whose experience, by and large, has resulted in a high degree of patient satisfaction.

The benefits of a universal single payer program have motivated a number of states and organizations to consider seriously legislation for such a program. Prominent among these are California, Maryland, Massachusetts, and Ohio and Physicians for a National Health Plan, Universal Health Care in Ohio.

The advantages of a universal Health plan are many. They include:

- Coverage of all residents of a state, without the need to administer the fine points of eligibility as for example, in Medicaid.
- Elimination of unnecessary paper work by placing administration in a single agency.
- Uniformity of benefits to insure equality of treatment.
- Uniformity of payments to all health care providers, either on a fee-for-service or capitation basis, with geographic and practice variations.
- Creation of review bodies to assess payment structures, quality of service, distribution of care, acquisition of technology, changes in services, capital investment and improvements, etc.
- Assessment of financing mechanisms which could include payments by the federal government based on past expenditures in Medicare and Medicaid with increases according to the medical practice index; inclusion of health care provisions under workers compensation, auto insurance, homeowners insurance as incentives to business and industry to get out of the health care business; revisions of the tax code to finance health care, with consolidation of the numerous business taxes into one amount to take care of lost wages under workers compensation, temporary disability, and unemployment insurance.

Hawaii cannot continue to temporize. Our population is growing older and living longer; we have 4,000 to 10,000 new immigrants who come to this state every year; we have populations that need care, particularly the Hawaiians whose statistics on health care represent a shame of negligence. There are new methods of treatment presaged by discoveries in genetic manipulation and technology.

We cannot leave health care to market economics and its cover of profit making via competition. Health care for all residents does not belong in the competitive arena. It belongs in the area of providing equal care to all who need care.

Let the discussions begin on the merits of a universal single payer health plan to achieve this equality.



HAWAII POISON CENTER

OAHU: 941-4411

NEIGHBOR ISLANDS TOLL-FREE:

1-800-362-3585

Free Hotline 24 Hours a Day.

POISON CENTER TIPS

- Keep the number of the Hawaii Poison Center on or near your telephone.
- If you suspect a poisoning, do not wait for signs and symptoms to develop. Call the Hawaii Poison Center immediately.
- Always keep Ipecac Syrup in your home. (This is used to make a person vomit in certain types of poisoning.) **Do not use Ipecac Syrup unless advised by the Hawaii Poison Center.**
- Store all medicines, chemicals, and household products out of reach and out of sight, preferably locked up.
- A good rule to teach children is to "always ask first" before eating or drinking anything—don't touch, don't smell, don't taste.

Donate to help us save lives.

Mail checks, payable to:

Hawaii Poison Center

1319 Punahou Street, Honolulu, HI 96826